

ETHICAL  
ISSUES IN  
CHRONIC  
PAIN  
MANAGEMENT

EDITED BY  
MICHAEL E. SCHATMAN



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# PAIN MANAGEMENT

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1. Ethical Issues in Chronic Pain Management, *edited by Michael E. Schatman*

# ETHICAL ISSUES IN CHRONIC PAIN MANAGEMENT

EDITED BY  
MICHAEL E. SCHATMAN

Consulting Clinical Psychologist  
Redmond, Washington, U.S.A.

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*This book is dedicated to my son, Joshua Harry. May he grow up into a world  
in which relief of pain and suffering is considered a fundamental human  
right rather than a commodity.*

M.E.S.





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## Preface

Chronic pain is a phenomenon that impacts the life of the sufferer in profound ways, as it is experienced not only nociceptively, but emotionally, socially, vocationally, financially, legally, and spiritually as well. To the patient, chronic pain represents a challenge unlike that associated with any other type of physical condition. Yet it is not only the patient who is challenged by chronic pain; the wide variety of chronic pain conditions that patients experience certainly represents a unique challenge to the health care professionals who valiantly attempt to treat them. Typically, cure is not a realistic goal for the practitioner or the patient. Accordingly, medical professionals are left with the obligation to reduce suffering, despite a frequent misunderstanding of what suffering entails. Many physicians and other health care professionals want nothing to do with chronic pain patients, simultaneously expressing feelings of frustration relating to their inefficacy in reducing suffering and contempt for the patients who are afflicted. Because of the difficulty involved in effectively treating patients with chronic pain, primary care physicians seek “dumping grounds” for them, hoping that other practitioners will carry the burden. The physician who is brave enough to make chronic pain management a part of his or her practice is faced with a myriad of ethical dilemmas, further complicating the treatment of patients in need of assistance.

While few would question the notion that patients and clinicians experience unique challenges associated with chronic pain, other entities are challenged by this affliction as well. The medical system now includes more than the physician and the patient, between whom a moral covenant ideally exists. This covenant entails a common will, shared by patient and practitioner, to work toward reducing the individual patient’s suffering. Parties not directly bound by this covenant have come to be included in the care that the patient ultimately receives, with this seemingly increasing list of parties including the insurance industry, hospital administrations, attorneys, the government (in various forms, including the DEA, the legislature, the executive branch, and the courts), ethics boards of the various professions involved in chronic pain management (whose principles often collide with one another), and research review boards. Sadly, the strength of the covenant between the practitioner and the chronic pain patient is compromised by the involvement of these extraneous parties, some of whom are motivated by the desire to serve the good of society as a whole as opposed to that of the individual patient, with others simply (and, at times, selfishly) motivated by cost-containment and profitability. Both the patient and the physician have lost their autonomy to work together as an effective team, with too many cooks spoiling the broth of patient relief from suffering.

This handbook was written in order to help all the parties involved in the care of the chronic pain patient understand the ethical (and related legal) issues associated with the efforts of professionals to assist patients in their efforts to find relief and reclaim their independence. The opinions of the illustrious group of

authors who contributed chapters to the book are not necessarily consistent with each other, and editorial efforts were made to maintain balance in presenting viewpoints that may not be harmonious. All the chapter authors, while renowned in their respective fields of practice and investigation, demonstrated admirable willingness to avoid dogmatic positions in interpreting the literature and offering opinions regarding what constitutes ethical practice.

*Ethical Issues in Chronic Pain Management* is divided into five sections. The [first section](#), Ethical/Philosophical Issues, includes chapters looking at the pain practitioner's responsibility to practice virtuously (James Giordano), ethical dilemmas experienced by the chronic pain patient (Debra E. Benner), ethical issues associated with treatment of patients at the end of life (Richard Payne), and the ethical failure of society associated with allowing empirically supported multidisciplinary treatment programs to become progressively less accessible to patients (Michael E. Schatman). While seemingly diverse, each of these topics shares the common theme of the integration of classical philosophical thought and the optimal management of chronic pain conditions. The authors of the chapters in this section agree that on both the individual and collective levels, allowing people to suffer needlessly is simply wrong.

The [second section](#) of the book, Disparities in Treatment, emphasizes the bioethical principle of justice, which is primarily localized to the domain of distributive justice. The multitiered medical system, which is evident in the American society, results in limited access to high-quality chronic pain management services for many on the basis of socioeconomic factors (1). Chapters in this text include analyses of underservice of specific groups of chronic pain sufferers, including children (Patricia A. McGrath and Danielle A. Ruskin), seniors (Raymond C. Tait), and members of racial and ethnic minority groups (Carmen R. Green). Each of these chapters promotes the mission of the Disparities in Pain Management Special Interest Group of the American Pain Society, which is currently chaired by Dr. Tait.

Part three of the book, Legal and Ethical Issues in the Pharmacological Treatment of Chronic Pain, is extensive, as the included chapters cover the greatest current ethical and legal controversies in the field of chronic pain management. Chronic pain practitioners are in agreement regarding the need to help alleviate suffering in our patients. Considerable disagreement exists, however, regarding the best means of doing so. An emphasis has been placed on chapters relating to the prescription of opioids on a long-term basis, particularly to patients with chronic pain of nonmalignant origin. During the 1990s and the early part of this decade, the pendulum swung from disdain for the practice of chronic opioid therapy to a possible overreliance upon this mode of treatment. The result of this paradigm shift has been not only problematic responses by many patients, but more aggressive monitoring of physicians by the DEA as well. Chapters in this section include an argument for consideration of chronic opioid therapy (B. Eliot Cole), an argument for the need to be cautious in considering long-term treatment with opioid analgesics (Jane C. Ballantyne), and a very important set of recommendations regarding the avoidance of legal and regulatory challenges to physicians who attempt to alleviate patient suffering through the prescription of opioids (Jennifer Bolen). Finally, this section includes a chapter by Ethan B. Russo on the benefits of cannabinoids in the treatment of chronic pain. This chapter was a late addition to the book, as progressively more states are passing legislation supporting the use of cannabinoids for pain treatment. However, in June of

2005, the U.S. Supreme Court curiously ruled that the federal government can ban the possession of the drug, even in states that have eliminated sanctions against its use for the treatment of illness. Dr. Russo's chapter is particularly important given the number of sufferers who have found medicinal marijuana to be an effective pharmacologic agent in their battles with chronic pain.

The **fourth section** of the book, *Medicolegal Issues*, consists of chapters on legal issues associated with the treatment of chronic pain. As a considerable proportion of chronic pain patients are injured traumatically or through repetitive motion at work, clinicians are faced with the challenge of providing the best possible care while simultaneously demonstrating sensitivity to the legal aspects of their patients' cases. Additionally, the commodification of medicine in the United States has severely limited the ability of medical professionals to provide optimal care to chronic pain patients. Confusion relating to balancing the interests of multiple clients (i.e., the patient, insurance carriers, case managers, attorneys, the employer, and hospital administrations) often results in an ethical conundrum for the chronic pain practitioner. To provide guidance, this section of the book includes chapters discussing ethical issues associated with disability determination (Jaye E. Hefner), treating chronic patients effectively despite the efforts of managed care to limit treatment (David L. Trueman), and ethical issues associated with providing expert medical testimony in cases involving chronic pain (Barbara L. Kornblau). These chapters have been included in order to help the chronic pain clinician gain perspective on the interaction between the law, ethics, and the provision of medical services.

The final section of the book, *Ethical Issues in Standards of Care and Research*, covers a wide variety of topics. Chapters in this section examine issues including ethical standards in the psychological evaluation of chronic pain patients (C. David Tollison and Donald W. Hinnant), the need for appropriate physical examination of chronic pain patients and the interaction of legal and ethical issues involved in implementing optimal treatment based upon findings (Nelson Hendler), the importance of clinical practice guidelines (Alexandra Campbell), and ethical issues involved in conducting chronic pain research (Robert J. Gatchel, Perry N. Fuchs, and Colin Allen).

Pain practitioners, as has been suggested by Giordano (2), are obligated to serve as *moral* agents as well as therapeutic agents to their patients. The practice of pain management is under assault by a number of forces (3), although this is thought to be true of medicine in general (4–6). Our hope is that *Ethical Issues in Chronic Pain Management* will provide clinicians with insights that will help them continue to practice the healing art of chronic pain management virtuously, while simultaneously avoiding potential legal pitfalls that may be deleterious not only to health care providers, but to their suffering patients as well. Patients with chronic pain, and society as a whole, cannot afford the demise of the patient–practitioner covenant. Emphasizing ethical and legal treatment will hopefully serve to keep the covenant alive.

Michael E. Schatman

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## Contributors

**Colin Allen** Department of History and Philosophy of Science,  
Indiana University, Bloomington, Indiana, U.S.A.

**Jane C. Ballantyne** Division of Pain Medicine, Department of Anesthesia and  
Critical Care, Massachusetts General Hospital, Harvard Medical School, Boston,  
Massachusetts, U.S.A.

**Debra E. Benner** Hershey Medical Center, Hershey, Pennsylvania, U.S.A.

**Jennifer Bolen** The Legal Side of Pain, Knoxville, Tennessee, U.S.A.

**Alexandra Campbell** Pain Program Accreditation/Outcomes Measurement,  
American Academy of Pain Management, Sonoma, California, U.S.A.

**B. Eliot Cole** American Society of Pain Educators, Montclair, New Jersey, U.S.A.

**Perry N. Fuchs** Department of Psychology and Biology, The University of Texas  
at Arlington, Arlington, Texas, U.S.A.

**Robert J. Gatchel** Department of Psychology, College of Science, The University  
of Texas at Arlington, Arlington, Texas, U.S.A.

**James Giordano** Center for Clinical Bioethics, Georgetown University Medical  
Center, Washington, D.C., U.S.A.

**Carmen R. Green** Department of Anesthesiology, University of Michigan  
Health System, Ann Arbor, Michigan, U.S.A.

**Jaye E. Hefner** Department of Physical Medicine and Rehabilitation,  
Spaulding Rehabilitation Hospital, and Department of General Internal  
Medicine, Massachusetts General Hospital, Harvard Medical School,  
Boston, Massachusetts, U.S.A.

**Nelson Hendler** Mensana Clinic, Stevenson, Johns Hopkins University School  
of Medicine, and School of Dental Surgery, University of Maryland, Baltimore,  
Maryland, U.S.A.

**Donald W. Hinnant** Carolina Center for Advanced Management of Pain,  
Asheville, North Carolina, U.S.A.

**Barbara L. Kornblau** Departments of Occupational Therapy and Public Health, Nova Southeastern University, Fort Lauderdale, Florida, U.S.A.

**Patricia A. McGrath** Divisional Center for Pain Management and Pain Research, Department of Anaesthesia, The Hospital for Sick Children, The University of Toronto, Toronto, Ontario, Canada

**Richard Payne** Institute on Care at the End of Life, Duke University Divinity School, Durham, North Carolina, U.S.A.

**Danielle A. Ruskin** Divisional Center for Pain Management and Pain Research, Department of Anaesthesia, The Hospital for Sick Children, The University of Toronto, Toronto, Ontario, Canada

**Ethan B. Russo** Department of Pharmaceutical Sciences, University of Montana, Missoula, Montana and Department of Medicine, University of Washington, Seattle, Washington, U.S.A.

**Michael E. Schatman** Consulting Clinical Psychologist, Redmond, Washington, U.S.A.

**Raymond C. Tait** Department of Psychiatry, Saint Louis University School of Medicine, St. Louis, Missouri, U.S.A.

**C. David Tollison** Carolina Center for Advanced Management of Pain, Greenville, South Carolina, U.S.A.

**David L. Trueman** Columbia University School of Law, New York, New York, U.S.A.

**1**

## **Pain, the Patient, and the Practice of Pain Medicine: The Importance of a Core Philosophy and Virtue-Based Ethics**

**James Giordano**

*Center for Clinical Bioethics, Georgetown University Medical Center,  
Washington, D.C., U.S.A.*

### **INTRODUCTION**

The classical definition of medicine is the science and art of treating and healing. The applied focus of this science and art is the patient. The word patient is etymologically derived from the Latin *patiens*, the one who suffers. Thus, at its core, medicine is dedicated to the treatment of suffering. However, contemporary medicine has embraced a more technocentric, curative model that has utilized advanced diagnostics and therapeutics in the elucidation and treatment of disease. While the efficiency of this orientation upon eradicating disease mortality and improving the public health is incontrovertible, there are certain conditions that are not well served by such a unitary approach. I posit that the illness of chronic pain is one such condition. Although there is a moral obligation to treat pain, the technological advances that have enhanced other aspects of medicine have not led to universal progress in pain therapy and the sole use of the technocentric approach is inadequate to address and treat the broad dimensionality of chronic pain. Using a phenomenological orientation<sup>a</sup> to examine both the nature of pain and the medicine, I argue that the essence of these experiences is such that their clinical intersection requires a virtue-based foundation to allow the physician to best approach the ethical issues inherent to this complex, experiential territory.

### **A PHENOMENOLOGICAL ORIENTATION TO PAIN<sup>b</sup>**

As defined by the International Association for the Study of Pain (5), pain is a noxious stimulus that causes unpleasant sensations and perceptions that can produce cognitive and behavioral responses of avoidance and aversion. Pain that is directly attributable to a noxious stimulus and/or some identifiable organic insult is classified as nociceptive pain, in that it activates a subset of high threshold (i.e., nociceptive) afferent fibers in the “normal” physiologic transduction and transmission of information that is “functional” to the organism. Such pain has

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<sup>a</sup> I do not presume to use the complete phenomenological method. Rather, I utilize the phenomenological technique of eidetic reduction, or bracketing, to allow for an ataractic identification of the “essence” or eidos of the experience of pain and medicine. A complete description of the phenomenological method from which this approach is derived can be found in Refs. 1 and 2.

<sup>b</sup> A complete phenomenology of pain is beyond the scope of this work; more comprehensive discourse on this topic may be found in Refs. 3 and 4.

recently been called “eudynia,” to reflect this physiologic functionality. In contrast, pain can also be generated and perpetuated by nonnociceptive mechanisms through processes of peripheral and central sensitization within the neuraxis from spinal cord to brain (6,7). This is classified as neuropathic pain, and has been termed “maldynia”<sup>c</sup> in light of its pathophysiologic basis. It has become increasingly apparent that such pain exists at the end of the continuum from disease-process to illness manifestation(s), and involves multiple systems affecting the definable “state” or “being” of individual persons. While nociceptive pain may frequently be served by a disease-based, curative medical model, non-nociceptive, maldynic pain most often is not. Maldynic pain can be caused by and induce changes in heterogeneous neurochemical substrates (6,7). While a more thorough definition of these mechanisms may be useful in understanding the “disease-process” that may initiate maldynic pain<sup>d</sup>, at present, it is not fully known how the manifestations of this pathology hierarchically advance to affect the subjective experience of the “illness phenomenon” that impacts many, if not all domains of the pain patient<sup>e</sup>. Thus, pain patients cannot be considered as a homogeneous, universal population that can be uniformly fitted into an objectively assessed disease-state. Rather, the illness of maldynic pain is an event that occurs in unique persons, and as such, is defined by the extent and dimensions by which it occupies and distorts the life of each individual.

<sup>c</sup> The etymologic origin of the terms eudynia and maldynia may respectively infer notions about the “rightness” and “badness” of these pain states. From a nosologic perspective, this may be relevant to the function of eudynic pain to evoke responses and behaviors that have some benefit to the survival or well being of the organism. Maldynic pain, on the other hand, does not serve any beneficial function, as it persists beyond the point at which chronicity should engage recuperative mechanisms, and thus provokes maladaptive and denigratory effects. This classification speaks of the “purpose” of pain as both biological and perhaps evolutionary function, and can frame maldynia as a modern or postmodern illness (Ref. 8) However, it should be noted that these terms may also lend axiological significance to these conditions, and thus have connotations of blame and stigmatization. In view of these semantic issues, I suggest that these terms be used taxonomically to classify types of pain syndromes according to mechanisms and effects, but not be used as diagnostic categories for patients. Note also that the term “maldynia” and “maldynic illness” are used to address and describe the trajectory of chronic pain to a pervasive experience of the lived body. This trajectory can, and most often does, lead to suffering; however they are not identical terms in this discourse. Suffering can be caused by pain as in the present case, but can also be caused by other life events. In this work, the illness of maldynic pain is presumed to evoke considerable suffering, but the (direct) source of this is pain qua illness. For a discourse on the impact of pain and suffering, see Ref. 9. A detailed discussion of the multidimensionality of suffering and pain can be found in Ref. 10.

<sup>d</sup> According to Ref. 11 “... disease ... is something an organ has; illness is something a man has.” I concur with this definition and consider disease as a biologic entity inducing some definable pathologic change in tissue(s) or systems. Illness is herein regarded as a subjective experience that can affect, and be affected by a variety of existential domains of a person’s life. There is a considerable dialectic regarding the nature of disease and illness; exploration of this dialectic is beyond the intention of this writing; however, a more complete examination may be found in Ref. 12.

<sup>e</sup> “... However, viable a knowledge of pain mechanisms may be to the scientist or physician, such “secularization” is irrelevant to its first-person experience by the patient. As well, such knowledge does little, if anything to represent the existential experience of a particular patient’s pain to the physician” Ref. 13.

In many ways, maldynia defies the technocentric medical model. Contemporary medicine vests considerable heuristic power in images. The ability to “view” sense data has become almost intrinsic to the act of diagnosis (14). While this is an important part of objective evidence-based practice, it may also contribute to what Wittgenstein (15) has termed “picture thinking,” which tends to deny the reality of an event or experience unless it can be empirically validated. But, maldynia is less than objectifiable by third person, technologic means (for a broader explanation, see Ref. 9). There are no laboratory tests to specifically confirm the presence or extent of a particular patient’s pain. Although advanced neuroimaging [e.g., functional magnetic resonance imaging, positron emission tomography and magneto-electroencephalography (mEEG)] can provide an indication of those brain regions involved in pain processing, even the most sophisticated analyses of neuroimaging data cannot afford an accurate representation of each person’s unique experience of pain. The activation of various neuroanatomical pathways may impart significant distinctions in the subjective experience of pain in a particular person. Such variation may hierarchically engage anatomical structures (and/or specific regions within neural fields) to conjoin memories, expectations, beliefs, and the cognitive and emotional variables that create the perceptions and higher consciousness that create the first-person experience of pain (16,17).

Hence, the conscious “self” changes. The patient becomes focused upon a new attunement to numerous (if not all) domains of their existence, which are now experienced as “off-balanced” by pain (18,19)<sup>f</sup>. The lived body is now understood in terms of what cannot be done (disability), difference from the painful life (dissonance), emotional suffering (despondence), and vulnerability (dependence). Lieb (22) maintains that a person cannot be wholly in the present, because each is linked to the past and the future. For pain patients, the temporality and perceived horizon of their life worlds are determined by pain: retrospection imparts despair over what was once and is now lost, prospection fosters anxiety about the unknowns in a future seen as increasingly constricted by vulnerabilities and limitations. This may clinically present as comorbid depression and/or anxiety (23,24) that may produce neurochemical changes capable of reciprocally exacerbating the constellation of symptoms to advance the patient further along the illness continuum (6,7,25)<sup>g</sup>.

The “self-understood” physical experience of maldynic pain eludes language (9)<sup>h</sup>, and the pain patients frequently exaggerate descriptions of the severity of pain and/or its symptoms in an attempt to explain their existential despair (27–29). This can produce enigmatic difficulties in the evaluation of maldynic pain, because many of the research and clinical assessment tools are based upon magnitude estimations (30) that are relative to the patient’s prior experience(s). In the absence of technologic means to objectively evaluate and quantify a patient’s pain, the physician must rely upon subjective descriptions to gain access into the life world of the patient as affected by pain. However, as can be seen, while explanation may be

<sup>f</sup>See also Refs. 20 and 21.

<sup>g</sup>The reciprocity of pain and cognitive and emotional manifestations has led to considerable “chicken-or-the-egg” speculation about the bi-directionality of effect and causation. For a discussion of this issue, refer to Ref. 26.

<sup>h</sup>There is the hypothesis that the capacity for linguistic ability is the basis for higher consciousness. This has led to the proposition that the linguistic issues involved in pain may reflect the fact that pain may represent a unique form of consciousness.

inherently difficult, this narrative is critical to establish the nature, meaning, and impact of pain upon a particular person (*vide infra*)<sup>i</sup>. This imparts a contextual understanding of the patient as a person, beyond that which can be acquired through solely technical and scientific knowledge. This takes time and cannot be easily accomplished within the confines of a 6 to 16 minute history and physical examination, as has become de rigueur consistent with much of the “turnstile medicine” driven by the technocentric imperative of speed (33). I maintain that the beguiling inadequacies of maldynic pain interventions may reflect an incomplete understanding of this phenomenological construal of pain, based upon the relative refractoriness of these unique patient-centered variables to the diagnostic and therapeutic limitations of a technically oriented model of pain medicine.

## A PHENOMENOLOGICAL ORIENTATION TO PAIN MEDICINE<sup>j</sup>

Although pain medicine has developed into a specialty field, its identity remains somewhat noncohesive and its integrity as a practice is subject to the disruptive influence of commoditization and sociopolitical forces that are often economically motivated (35). Yet, it is the nature of pain and the existential dilemma of the pain patient that provides the foundation of what pain medicine should and must be. A phenomenological orientation to medicine may allow a better understanding of the role and ethical obligations of the physician whose focus is treating pain. If we reduce medicine to its essence, we find it to be an intersection of the life world of the clinician as both therapeutic and moral agent, with that of the vulnerable patient who seeks the practice of the clinician to achieve a definable healing end. MacIntyre (36) defines a practice to be a cooperative interaction in pursuit of “goods” (i.e., acts and ends) that are intrinsic to that relationship. Such moral goods are achieved by conforming to standards of excellence within the profession. The literal “profession”<sup>k</sup> of medicine is the act of one person proclaiming to possess the abilities necessary to treat and heal those persons who are made vulnerable by disease and illness (37,38). The moral good of this practice is achieved through virtue, character traits of excellence that predispose the practitioner to act toward the attainment of the moral end, or telos, as professed (39–41). For the pain practitioner, that end is the effective (i.e., biomedically right) and beneficial (i.e., benevolently good) treatment of pain.

To be sure, the act of medicine is a unique experiential event<sup>l</sup>. It is embodied by the clinical encounter that allows for both experiential intersubjectivity (i.e., an intersection of phenomenological life worlds) and the execution of right and good

<sup>i</sup> This reflects a component of the hermeneutic circle of that which is “understood” or interpreted in the first-person sense, cannot be “explained,” and is the basis of the *ti esti* question, as applied to the phenomena of pain. Further discussion of the hermeneutic approach, with particular emphasis upon the notions of understanding (*Verstehen*), explanation (*Erklaren*) and the nature of self can be found in Refs. 19,31, and 32.

<sup>j</sup> For a more complete phenomenology of medicine, refer to Ref. 34.

<sup>k</sup> Etymologically derived from the Latin, *profiteri*, to declare or publicly announce. Thus, a *profession* is literally a declaration or announcement.

<sup>l</sup> And particularly so of pain medicine given the phenomenological nature of pain, the inherent subjectivity and broad impact of which cannot be evaluated by technologic means, thereby necessitating that the physician return to the intellectual and moral virtues to allow intersection of the life within the patient—physician relationship.

acts (42). The intersection of life worlds is particularly important to pain medicine; it allows the patient to share their lived experience of maldynic illness and thus gives the physician insight to the complexity and uniqueness of a specific patient with this illness. To fully apprehend the impact of each patient's pain, the physician must use a person's narrative and history to establish the concrete reality of the individual life world. Taken together with the objective data, this allows for the establishment of a diagnosis to frame this illness within a generalizable commonality (i.e., the categorical diagnosis). The diagnostic step functions as an act of disclosure, observation, and rationalization for appropriate subsequent intervention (i.e., the relevant diagnosis) (43). However, it is also a moral act of privilege, ritual, labeling, and power. As both a technical and moral act, diagnosis should be based upon both scientific skill and humanitarian art (43,44).

Such disclosure and interpretation position the patient and physician, respectively, at an intersection of their life worlds that allows the patient to ask, "Can you help me?" and the physician to assess, "What is wrong?" and "What can be done?" Recall that in the literal sense, the profession of medicine is a declaration of possessing technical ability as well as a commitment to act in the patients' best interests. Although Veatch (45,46) views this as a social contract, May (47,48) and Pellegrino (49) maintain that it is a moral covenant and the foundation of the reciprocal trust inherent to the medical relationship: the patient must trust that the physician is competent and virtuous; the physician must trust that the patient is truthful and equally committed to the telos of an effective and beneficial treatment/healing (49).

Yet, from this telos also arises the central ethical issue inherent to medicine: for each unique patient, what constitutes a right and good treatment? The complexity of how pain affects the life worlds of unique persons demands that the physician use distinct domains of knowledge (i.e., circumstantial, experiential, abstract, etc.) to apprehend the ontology of maldynic illness (50–52). However, the clinical situation involving a unique pain patient and a particular physician can create numerous therapeutic options that may be based upon technical, social, economic, and personal factors. Thus, according to Pellegrino (49), the critical act of moral agency lies not in the question "what can be done?" but in the question "what should be done for this patient?"

This question is prudential and involves both technical and ethical evaluation. Phronesis, originally defined as the intellectual virtue of "practical wisdom" by Aristotle in Book Six of *Nicomachean Ethics* and somewhat amended for application to medicine by Pellegrino (49) and Pellegrino and Thomasma (40), affords the ability to weigh multiple, divergent lines of information, and evaluate and resolve ethical issues toward the optimal execution of clinically rational acts in the care of unique patients. This enables the physician to select "the right grounds toward the right people for the right motive and in the right way . . . to the best degree" (39,53), thus underscoring the indispensability of phronesis to medicine. Thus, while some explicitly doubt the relevance or possibility of a virtue-based medical ethics in a pluralist society and contemporary medical culture (45,46), I argue for the essentiality of virtue ethics, in general, and the virtue of phronesis, specifically, to guide the physician as a therapeutic and moral agent confronting the ethical dilemmas and medicolegal issues inherent to the practice of pain medicine. As a basis for this argument, I maintain that phronesis provides the capacity to make complex clinical decisions by evaluating the technical options for care, and balancing these accordingly with moral and abstract issues. This allows the



physician to appreciate and respect the patient as a unique person in a given circumstance, thereby acknowledging their human dignity, and by extension, their culture, beliefs, and needs. It also enables prudent reliance on, and use of other intellectual and moral virtues necessary to both the clinical encounter with this particular person and the ends of medicine, as a practice. This last point is important in that *phronesis* enables the physician to appropriately exercise those skills and acts by virtue, rather than by value(s) that have been superimposed upon medicine by societal convention, consensus, or ethical compromise.<sup>m</sup>

## PAIN MEDICINE IN THE CURRENT “CULTURE” OF HEALTH CARE

Despite national advocacy statements (55,56), guidelines (57,58), and state-level policies in 45 states (59) endorsing practices to more thoroughly evaluate and control pain, there continues to be considerable ineffectiveness, inequity, and impropriety in the treatment and management of maldynic pain (60). This becomes even more noteworthy in light of Congress having declared the 10-year period of 2000 through 2010 to be “The Decade of Pain Control and Research,” the introduction of the Pain Care Policy Act (HR 1863) in 2003, and its reintroduction in 2005 as the National Pain Care Policy Act (HR 1020).

This disparity of intention and execution reflects the realities of the current culture of medicine as created by contemporary society. The pervasive encroachment of postmodern technocentrism into medicine has instilled a climate of moral skepticism and litigiousness. The current medicolegal environment has assumed an increasingly antagonistic stance toward the use of medication. The notoriety of class-action suits related to emergent, initially unrecognized side effects of (analgesic) drugs (e.g., rofecoxib, Vioxx) and several cases in which public figures have been involved in coercive arrangements with physicians for the procurement of opioids have fueled a *Zeitgeist* of prohibition and retribution. Many physicians have become reluctant or completely opposed to prescribing these medications even when suitable or necessary for the relief of maldynic pain. While recent neuropharmacologic research has led to development of novel, non-opioid analgesics, most of these remain experimental, which precludes their broad use in nonacademic clinical settings (61). Although the serial and combinatory use of currently available nonopioid analgesics for nonterminal pain can be effective, a number of problems frequently occur, leading to asymptotic effects and the recurrence of significant pain: first, many patients rapidly progress through the use of nonopioids for pain control, thus necessitating the addition of an opioid to the regimen; second, the side effects of polypharmacy may warrant discontinuation of a combinatory approach in favor of the use of a single, more potent opioid (62).

Once it has been firmly established that nonopioid pharmacotherapy has become ineffective, there is abundant literature to support that chronic, maldynic pain can be satisfactorily managed or reduced through a stable dose of opioid(s) (63–65). While a standardized paradigm toward achieving analgesia is recommended (64), a simple, dogmatic approach in which “one size fits all” therapeutics are utilized is ineffective (66). It is vital that the physician understand as much as possible about the patient, the pain, and its experience to best select the agent,

<sup>m</sup> I use the definition of “value” as stated by Pellegrino 54, p.12: “... personal attributions of worth or interest attached to things, ideas, or people ... but they are not by that fact norms, principles, duties, or obligations.”

dose, and regimen that evidence has demonstrated will most likely effect a prudent and beneficial outcome. Pain relief is the end-goal of such therapeutic intervention, and patients have an ethical right to have their pain effectively and beneficially managed (58). The physician and patient must recognize the longitudinal and reciprocal obligations that such treatment entails. To be sure, opioid pharmacotherapy may be both therapeutically and morally sound, but the duration and complex nature of this treatment can create circumstances in which practical and ethical problems arise.

### **Ethical Issues**

The predominant issues of both therapeutic (i.e., scientific/technical and medical-legal dilemmas) and moral (i.e., ethical) relevance to pain medicine involve mismanagement characteristically effected by the inappropriate use of procedures and underprescription or overprescription of drugs (67). Each of these circumstances may reflect a disparity of shared responsibility in clinical decision-making that may have, at its root, a breakdown of beneficence-in-trust. As steward of knowledge, the physician must use scientific knowledge (episteme), skill and art (techne), balanced by phronesis to assess the relative effectiveness, benefit, and burdens of a particular treatment to a unique patient (49,68). Frequently, the overprescription of opioids results from the provision of "too much, too soon," with resultant physiological tolerance necessitating increasing doses of a drug to elicit the desired level of pain control. This may incur opioid-induced hyperalgesia, prompting the cycle of further dose escalation, tolerance, hyperalgesia, etc. (69). The use of an opioid that is inappropriate for a particular patient's type of pain, and/or failure to rotate agents to affect subpopulations of opioid receptors mediating specific and distinct forms of analgesia may also result in pharmacologic inefficacy, dose escalation and therapeutic impropriety (70,71). It is also important to note that patients' expectations of the outcomes of drug treatment may extend beyond pain control to functional domains of their life that may not be changeable and which are not consistent with the telos of pain medicine. Physicians must be sensitive to this and have the obligation to be truthful about the goals and expected attainable ends that a given therapeutic intervention is likely to provide. Describing the limitations of treatment and establishing the parameters for right and good intervention requires courage, integrity, and some degree of effacement of self-interest (72–74). Failure to do this violates a respect for patients' autonomy, deprives them of the knowledge necessary to consent to treatment, and impairs their ability to act with salience and rationality. As a result, patients may become distanced to the therapeutic relationship, increasingly noncompliant and may improperly (self-) medicate in an attempt to control their pain, affect other existential domains or revert the entirety of their life world to the prepain state.

Most commonly, when the right opioid is prescribed and administered at the right dose and schedule, the risk of addiction is rare (70,75,76). However, in cases of inappropriately high-dose opiate use, addiction may, and often does occur, and must be recognized as a clinical entity that requires referral beyond pain medicine to facilitate technically and ethically sound treatment (77). Numerous reasons can contribute to this trajectory: on one hand, it may represent a failure of the physician to utilize technical knowledge and phronesis appropriately to judge what is needed to treat a specific patient's pain, while recognizing their susceptibilities to addiction. However, the medical relationship is built upon a shared intersubjectivity, and patients too have moral obligations that are critical to the integrity of the

clinical encounter and the trajectory and success of its outcomes (78,79). Thus, some patients may enter this relationship with the intent to manipulate the physician to accommodate needs that fall outside of the telos of medicine (e.g., procurement of drugs for means beyond pain control). Such intentions and acts fail to respect the autonomy of the physician. Neither physician nor patient can exercise autonomy that is "absolute," and the demands of the patient do not supersede or "trump" respect for the autonomy of the physician (as a person and therapeutic and moral agent). These intentions and acts are a violation of beneficence-in-trust (49) and the physician is not morally obligated to acquiesce to such demands. Yet, irrespective of the cause, the occurrence of addiction is not the basis for labeling or medical disenfranchisement, because such stigmatization and abandonment invariably places the patient in diametric opposition to the healing domains of medicine (80,81). Each patient brings a unique life world to the clinical encounter. The physician must use skill and judgment to apprehend the nature of that patient's pain, and concurrent and past circumstances that may suggest or predispose noncompliance and impropriety of drug use. If these are present, it is the physician's responsibility to insure that these vulnerabilities are addressed so that the patient may receive treatment(s) appropriate to his/her needs.

In contrast to the circumstances and issues inherent to overmedication, the undertreatment of pain may be because of physicians' inadequate knowledge of the extent and nature of a particular patient's pain or due to a lack of familiarity with procedural interventions and pharmacological regimens that would best produce the desired ends of pain control in that unique patient (70,82). However, a more insidious and grave determinant of undertreatment of pain are physicians' manifest anxieties about the potential medicolegal ramifications surrounding the use of opioids and the fear of prosecution or professional sanction in circumstantially and medically complex cases with multiple risks. The progressive ubiquity of postmodern technocentrism has been inculcated in society to adopt a commercialized worldview and led to a pervasive consumerism. The moral and legal difficulties of the patient as a consumer bastardize the patient-physician relationship, and may lead the physician to retreat to a position of reluctance in an attempt to insulate against the resultant demands and burdens of this newly construed interaction. Such defensive posture is incongruous with the core philosophy upon which the practice of pain medicine is based. The profession of pain medicine is a declaration of the promise to help patients in their best interests and is an invitation to trust in the physician's knowledge, skill, and virtue to execute this effective and beneficent care. Pellegrino and Thomasma (40) state that acts of beneficence encompass good on four levels: (i) as an ultimate act toward another human, (ii) as the patient experiences it, (iii) for the patient's choices, and (iv) biomedically. The defensive practice of intentional undertreatment of the pain patient violates each of these domains. Further, by refuting beneficence-in-trust, it disavows respect for the patient as a person, and therefore deprives him or her due equity of care<sup>n</sup>.

<sup>n</sup> Further vulnerabilities can develop, and these patients may turn to complementary and alternative medicine (CAM) based upon this inequity of care and their disenfranchisement. However, philosophical differences may exist between CAM and mainstream medicine, including distinctions in the moral grounding of practice. CAM providers have an equal obligation to understand the essence of medicine *qua* medicine, its core philosophy, and to uphold the fiduciary responsibilities that are inherent to its profession and practice.

As well, the postmodern skepticism of moral foundation in favor of social contexts has exerted considerable influence upon medicine to adopt a cultural conformity. The plurality of contemporary culture may entail divergent concepts of morality based upon differing value systems and perspectives. These values can contribute to distinct constructs of rationality, and by extension, what constitutes reasonable and expected acts and ends. Together with the aforementioned consumerist manifestations, this has led to a highly litigious climate reflecting divergent societal values rather than a common moral integrity. To confront the often difficult situational complexities that may be superimposed upon medicine, the moral and intellectual virtue of the physician is essential to respond with intention and acts that are both focal to the telos of medicine and which are consistent across time as a matter of character, rather than simple adherence to social convention, or a changing set of values (36,83).

Given this cultural complexity, it can be seen how the sole use of *prima facie* principles might lead to apparent collision of the principles themselves due to a general lack of moral coherence within a pluralist society and the reliance upon social consensus of how the principles are to be used in differing circumstances. The heterogeneity of social values can produce considerable variation in the interpretation of both a lexical ordering of ethical principles, as well as their inherent meaning. Without a moral grounding, the sole application of principles can be manipulated to meet societal consensus and demands. As matter of fact, the Principlist approach is structured upon more fundamental, normative theories, and at least in concept, acknowledges virtue (84,85), but unless those underlying theories are coapplied and coultitized, the stand-alone use of principles can be somewhat difficult. A virtue-based ethics does not refute the application of *prima facie* principles. To the contrary, moral and intellectual virtue, in general, and *phronesis* specifically, allows the physician to intuit the relevance and appropriate use of principles and other ethical concepts (e.g., feminist ethics, casuistry, etc.) to resolve particular dilemmas, and to do so in a way that is consistent with a phenomenological understanding of pain and the telos of medicine *qua* medicine.

## **SUMMARY**

Maldynic pain is a complex illness that defies technocentric models of evaluation and treatment. To rightly practice pain medicine, the physician must understand the mechanisms of pain, appreciate its phenomenological experience and effects upon the life world and lived body of each pain patient. Intellectual and moral virtue and specifically *phronesis*, are needed to resolve ethical dilemmas, empower clinical decision-making, and enable rational exercise of skill and art to render a right and good healing to the patient made vulnerable by pain.

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**2**

## **Ethical Dilemmas of Chronic Pain from a Patient's Perspective**

**Debra E. Benner**

*Hershey Medical Center, Hershey, Pennsylvania, U.S.A.*

### **INTRODUCTION**

*"Pain is a more terrible lord of mankind than even death himself."*

Albert Schweitzer

All ethical considerations begin with self. No matter what lens of academic discipline one has acquired along the way, all ethical reflections are ultimately a mirror of self. Individual choices about actions, lifestyle, meaning, and purpose will always spring from this lifelong evolving definition. Any brokenness of self that results from trauma is no respecter of position or credentials. Chronic pain is a trauma that will alter one's view of self, and thus one's ethical outlook in many areas. This is an inevitable consequence of dealing with pain on a daily basis. Every chronic pain patient, therefore, brings a specific set of personal ethics into every encounter with professionals within the health care community. Patients' ethics must be respected and heard. The level of sophistication of thought, knowledge, or language will vary from person to person, but the ethical viewpoint of each person involved in the health care community must be a part of every decision-making process of patient care. The chronic pain patient brings a very unique ethical perspective to the process of health care, and this perspective has been too often overlooked by the medical community. Pain patients should not be regarded as passive observers to whatever the health care community decides. There is much more wisdom in regarding them as teachers in the chronic pain community. In order for any treatment plan to have a chance for success, the patient must be acknowledged as an integral member of the decision-making team.

Because no two people will ever possess the same set of life experiences, there will always be the potential for misunderstanding in any interpersonal encounter within the health care community. This is particularly critical to the chronic pain patient who often feels categorized or judged by his or her presenting pain condition. If the whole patient is not respected, and his or her hopes and fears are not heard by the medical professional, the relationship will end up being just one more frustrating and negative experience for the patient. The health care community should be a place of relative safety and openness for the patient who has usually encountered a substantial lack of understanding and concern from insurance carriers, employers, and even family members and friends. For most chronic pain patients, injustice has taken on a very real and personal meaning in his or her life. Personal integrity and personal ethics have usually been questioned by employers, insurance companies, and even some members of the health care community. Chronic pain patients often encounter either spoken or intimated charges of malingering or overly dramatizing symptoms. Difficulties with insurance companies and